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ABSTRACT

Three papers describe facets of a Winthrop, Massachusetts preschool program designed to facilitate the entrance of handicapped children into regular public school kindergarten. An initial paper concerns such administrative issues as screening, establishing a program philosophy, budgeting, working with parents, and supervising staff. The background, program model, and project procedures are reviewed in the second paper, while the third addresses the role of the speech and language clinician in the program. (CL)

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A Developmental-Behavioral Approach to Early Childhood Intervention in the Public Schools

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Adrienne Robb-Fund
Maria Walsh

A Panel Presentation
Council for Exceptional Children Convention
Kansas City, Kansas May 5, 1978

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The Administration of a Pre-School Program Based in a Public School

by

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Dallas, Texas

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The Administration of a Pre-School Program Based in a Public School

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Overview

Developing and implementing a pre-school program is a partnership amoung the school administrators, staff, parents, community, and other agencies. Without each cog fitting properly, the wheel jams on its uphill climb to a quality program. The professional assigned to administer the program has the responsibility for maintaining the uphill motion. S/he must be aware of the needs of the community, the attitude of the parents, the receptivity of the school administration, the power politics of community agencies. S/he must be able to perceive the difference between lip service and real support; to channel parent anger into positive action; to make competing programs allies rather than adversaries; to understand parent hostility as a cover up for mistrust, fear of the unknown, disappointment at past promises unfulfilled.

Awareness and perceptivity, however, are not enough. The administrator must be able to translate this awareness into facilitative behavior. S/he must be able to serve as a mediator between the school board and a parent group; a counselor to a distraught parent; a politician with the funding agency; a supervisor to program staff.

There are many ways of performing these various tasks including leaving some of them undone. Programs can run with distraught parents (especially when there are more clients than spaces in the classroom and parents are not knowledgeable about their rights); unsupervised teachers (especially when there are more teachers than teaching positions); or lack of good relations with other agencies (especially when your agency has all the money). Some programs can even run without student growth ("What else can you expect from students this handicapped with those parents?")

Let's assume, however, that all of us are super conscientious perfectionist professionals that want everything to be outstanding. Or, to be more realistic, that we want to maximize the opportunity for growth for the students in the program. What must the administrator do to achieve this best of all possible programs? First, s/he must know the population to be served or know how to identify it. Second, s/he must decide which educational philosophy will be used in the program. S/he must determine where the program will be housed, the type and amount of staff and equipment needed to run the program. Next, s/he must be aware of legal mandates and state and federal funding available to help sell the program at the local level. Last, and most important, s/he must reach out to other staff members and parents so that they may share in the problem solving and planning.

Once s/he has decided what the ideal program ought to be, the administrator approaches his/her most difficult task: making compromises between that ideal program and the realities of the community in which s/he works such as the resources available, the average expenditures for other children in the district, community expectations based on other programs already existing in other agencies. And even more important, s/he must decide what compromises s/he is not willing to make. What parts of the program will s/he not give up? What will s/he put her/his job on the line for to keep in the program? When does s/he say, "Either keep this in the program (i.e. 2 aides) or don't have one at all?" Each administrator must answer these questions for him/herself. The answers will depend on how much of a risk taker s/he is. However, the degree of awareness of his/her standards and limits as to the compromises s/he is willing to make with those standards will be highly related to the morale of the staff and in turn the children and their parents.

An administrative philosophy of "anything goes as long as we have a program" can lead to a staff who feel unsupported, at the mercy of the whims of parents and principals, and as a result, demoralized.

What were the politics and philosophies, of this program? What were the limits set on the compromises that were made to insulate the program against staff demoralization?

Five aspects of the program will be described as examples of this process: screening, establishing a program philosophy, program costs, working with parents, supervising staff.

Screening

The regulations accompanying the Massachusetts Comprehensive Special Education law referred to here after as "766", specifically enumerate procedures for screening 3-5 year olds. What the regulations do not specify (or even intimate) is how to humanize a mechanistic artificial set of experiences (otherwise known as a "screening test") for children who have never been in school before and, therefore, have had no experiences with strange adults asking them to do outlandish things. (Some of these young people know they shouldn't even talk to strangers, let alone skip or hop for them.) Unless they have older brothers and sisters, they also don't know that you are supposed to do what appears to be meaningless activities for strange adults when your in a school or what resembles one, (such as a screening clinic).

Screening tests are reliable measures of many children who are developmentally at age level. However, they may also falsely identify children as developmentally behind, who actually function at or above age level outside the testing situation.

Pre-school children may flunk screening tests because they don't want to do what's asked of them not necessarily because they can't. Although the 766 "regs" say you should inform a parent "in writing" when his/her child flunks the screening; no letter says it the way you can verbally, especially when the letter goes to the parent of a child who can perform the requested activity, but "wouldn't" or "didn't".

My philosophy is evident in the above paragraphs. Screening is valid for separating the "no problem" or "at or above age level child" from the "maybe he is behind" child. But it does not separate out the "maybe" from the "definitely is behind by at least one year" children.

In our program, during the second implementation year of 766, staff time available to do full evaluations of all the "maybe" children was extremely short with long waits between referral and testing. There were no funds available to hire extra testers.

The early childhood teacher was concerned that children might be erroneously identified. Therefore, we decided to implement a second level of screening for those "maybe" children. The parents of children who had low scores on the test were asked by phone to bring their children back for a second screening. They were told this would be conducted in a more natural setting for the child.

Parents were much more positively responsive to the phone call rather than the letter which we sent to parents the year before. Teacher morale was high because she felt her concerns were heard and she had a chance to participate in finding a solution. The limits of compromise were set. Screening must have a second screening as a component. The second screening was low cost to fit into budget restraints. In fact, this more informal screening, described in detail by Ms. Robb-Fund on pages 6 & 7 of her paper, was so successful that it became the standard screening procedure.

Program Philosophy

The children that were screened and referred to the program ranged in their abilities from gifted to 3 month old developmentally. The administrator must decide who will be chosen when only one program is available. Criteria for entry into this program was based on the following:

(a) The law and our limits as defined by the school board.
This eliminated the gifted child.
(b) Other programs available.
The district's regular program served children with mild special needs in the regular kindergarten. Cerebral Palsy Foundation and Mental Health had programs for those students who were developmentally 6 months or less.

(c) Funds available.
Funds were limited which precluded expensive medical staff and therefore eliminated children with uncontrolled seizure disorders.

Children were accepted whose development was delayed for more than one year in one or more areas with the exceptions mentioned above.

Once the client population was determined, the next step was to decide on the educational philosophy of the program. Decisions related to staffing, prior staff experience, equipment, types of support services-all depend on program philosophy. I am sure that those administrators whose training is in Early Childhood have already settled on the type of program they find best. However, Early Childhood was not my area of expertise. I spent the month before I wrote the final proposal for the program visiting as many existing pre-school programs as possible. As a result of these visits, I drew the following conclusions:

(a) Taking children out of the mainstream of classroom activities for OT, PT, speech, or play therapy interrupted valuable learning experiences. These learning experiences frequently took place at unpredictable times not necessarily when scheduled by the adult. Special therapy time depends on adult schedules.
(b) Therapy was isolated from the ongoing learning process. Excellent therapeutic gains were not necessarily generalized to classroom activities.
(c) However, completely unstructured classrooms with no ancillary services was not the answer either.
In these classrooms, activities were made available and adults were around if a child needed them, but if a child didn't choose an activity he needed to learn, he just did not get that training.

What was needed was a program in which specialized training occurred within the natural environment of the child and was immediately generalized into classroom activities to be practiced repetitively. I asked the person who would be the teacher for the program and the speech therapist to visit the same programs I had. I was fortunate to know who they were going to be. They came up with the same conclusions that I did.

As a result, the program was designed so that no child was scheduled out of the room for therapy. Rather, the adult consultants were scheduled into the room. Their task was to help the teachers better design the classroom activities so that the activities themselves would be more therapeutic. The philosophy of teaching would be a combination of a developmental and behavioral approach which will be described in detail by Ms. Robb-Fund.

This program design was foreign to many of our parents and some of the consultants. Frequently, the quality of a program is measured by how many hours of one-to-one PT, OT, speech the child receives. We believe in our program design however. Whenever a novel program is introduced

into the community it is critical for the administrator to strongly support it. It is not fair to the teacher to require him/her to defend an unfamiliar concept to disagreeing parents and doubting professionals. In this instance, the teachers were encouraged to refer all complaints to me. I took the responsibility to defend the program and explain its philosophy. We also had an open door policy. Anyone could come visit (with advance notice) and watch the program in progress.

One parent requested play therapy for her child. I asked the psychiatrist to first see the child as he behaved in the program, then see him individually. He agreed and spent a morning in the classroom. His recommendation was that he could not think of anything he could do in one-to-one play therapy with the child that was not already being done in the classroom.

Program Costs

How are costs kept down? How can one receive extra help from specialists at a reasonable rate? The program administrator must have either direct responsibility for staffing and budgeting or must have access to someone who does. S/he must have knowledge of all federal and state funds available, not only in special education, but in such areas as counseling, health, psychology. S/he must be able to review budgets for materials and supplies for other programs such as kindergarten to see how materials can be shared or money saved from combined ordering. In these ways s/he can obtain maximum benefit from limited resources. In addition, the administrator needs to have control of scheduling support staff or has to work closely and cooperatively with someone who does and who is able and willing to use staff in new ways.

The Winthrop pre-school program was funded through seven different resources. A title VIb grant was written to provide the speech therapist, aides, and some equipment. An 89-313 grant was written through a local special education consortuim to provide occupational and physical therapy services. The local Association for Retarded Citizens donated a refrigerator and one way window. A consulting psychologist was provided by the Department of Mental Health Community Clinics. The school psychologist and school social worker's schedules were adapted to include testing and consulting services to the program. The teachers worked closely with Department of Welfare who attended core evaluations on certain children. Health services were provided by the school nurse.

To tuition the 8 students to a private school would have cost the district $44,000 including transportation. This program cost $10,000 the first year; $20,000 the second year, and $27,500 when completely absorbed at the local level. With a morning and afternoon program (16 students) this program cost remains at $27,500, while tuition out costs would double: (See Figure I)

Figure I

Budget

1	teacher	$12,000	
2	aides @ 4000	8,000	
½	speech therapist	6,000	
	equipment	2,000	(one time cost)
	supplies and materials	1,000	($500 one time cost)
		$30,000	

In-kind costs

(a) rent expense
heat, light, janitorial service;
room

(b) staff
nurse, psychologist, social worker,
core evaluation team, principal, P.T., O.T.

(c) fringe benefits
insurance, retirement

(d) building and central office administration

Parents as Partners

Parents can and want to help. They can be advocates for your programs not adversaries. They can be on the same team, not "the enemy". Parent advocates for handicapped children, especially those active in local associations, may know local politics far better than you. It is important to spend time working with them as a team in your efforts to get programs off the ground. In order to gain parents as allies, you do not need to "do what they want right or wrong". Rather, you need to know what would be an educationally sound program for their child that meets the regulations of your state laws and support that program. You need to have a sound educationally valid basis for that program plan and be willing to go to a hearing on it, if the parent disagrees. You also need to be willing to change the program if you have made a mistake and if the parent does find a valid weakness in the way it is implemented.

You must keep the same program standards for all children regardless of parent pressure. If you always try to be as fair as possible; If you always make decisions based on sound educational theory and practice; if you listen to parents always with the possibility you or staff members may have made a mistake, you may not be liked by all parents, but you will be respected by most. It is difficult for them to accuse you of being biased or not caring about their children.

As an example, let me briefly describe the relation I as an administrator had with the parent who was most instrumental in helping us obtain some of the funding for this program. Mrs. Smith has been a foster parent for about 38 children all with some handicapping condition. The Greater Boston Association for Retarded Children named her "mother of the year " in 1976. She went to every school board meeting. She was vocal if she disagreed with what she heard. As you may imagine she was a legend in the town. None of her foster children went to the public school. All went to private school under state contracts until 1974, then with the advent of "766" with local funds. The town had always paid 50% of the transportation costs of the foster children to their private schools.

Joey, her youngest and most recent child was 4 years old. He, perhaps, would be her last, since she was getting along in years. Joey had garbled speech and some organic birth defects. He was very active; his measured IQ was 75. He was in a nursery program for retarded pre-schoolers run by the Department of Mental Health. He had temper tantrums there and was recommended for play therapy. At his Core Evaluation it was recommended that he not return to the program for the retarded, but rather join our public school program described in this panel. Mrs. Smith felt the program as we described it would not work for Joey, she wanted him to continue in the Mental Health program. That program would not have cost the school system anything that year (Mental Health paid for it for one more year 1976-77). However, the team felt, cost or no, it was the wrong program for Joey. We wrote the Educational Plan to meet Joey's needs as we saw them.

As administrator of the program, I had been to most of the Core Evaluation meetings. I took the responsibility of meeting with Mrs. Smith and showing her the plan. I said that if she disagreed she had the right to sign that she did not accept the plan and ask for a hearing. She responded that if we were that convinced, she would try it with the option to change her mind. This process took several months. However, all during this time Mrs. Smith helped us fund our program. In fact she personally spoke to the Associate Commissioner for Special Education at the state level when our funding was cut off at the local level. She was a parent representative on the state advisory committee (a group that heard all appeals not resolved at the local level) that met with the Associate Commissioner.

As a result of her conversation with the Commissioner, we were able to obtain state funding to support part of the program. The Superintendent, with school committee approval then agreed to also partially support the program, increasing support by 1/3 a year for three years.

At the end of Joey's year in our program, Mrs. Smith was delighted with his progress, which was even beyond our own expectations. We felt Joey was ready for regular first grade with a resource room for support. Mrs. Smith, however, felt that he could never "make it" in public school.

She had found a hospital day school program for aphaisic children that she felt was more appropriate for him. They were willing to accept him and had an opening. Again, we felt Joey needed a normalized setting to progress. We visited the day school program and felt that it was not for him. Again, we had several meetings and again we said she had a right to appeal our decision.

During all this time, Mrs. Smith was instrumental in getting the Winthrop Association for Retarded Children to fund a one way window for the pre-school program.

Mrs. Smith finally decided to try the public school program. She said, "You were right the last time. I guess I need to give it a try." Joey is doing well in his public school program. The first of Mrs. Smith's 38 to be in a public school.

Staff supervision and support

Finally, and very important, the administrator must be only a telephone call away from the staff-particularly during the early months of the program. Ideas don't always work out; renovations are behind schedule; consultants don't want to work inside the classroom; parents complain; buses are late, children are accidently injured; staff have conflicts; bus lines refuse to pick up children who are not ready. The teacher may have the ability to work these things out herself, but she does not have the clout to do so in an authoritarian environment such as exists in most schools.

If the teacher feels unsupported, her/his morale decreases. This cannot help but affect the quality of teaching. The administrator needs to handle the problems outside the classroom like the transportation without involving the teacher. S/he must also help the teachers with in-classroom problems by observing in the classroom, meeting with the teachers, listening to them, summarizing for them what appears to be a problem, asking them questions, praising good teaching techniques. As much as possible s/he must serve as a facilitator through which the teachers solve their own problems. There is no sure gimmick that works with all children.

Teachers do not fail or succeed. Rather, students grow or do not grow. The successful special education teacher knows that the student changes himself/herself. The good teacher provides the student with the opportunity for growth. If the student doesn't grow with that opportunity the teacher tries to find another one and another until one clicks and the student's face lightens up to signal he understands.

The good administrator provides the teacher with as many supplies, materials, encouragement, praise, support, as s/he can to keep her/him from becoming discouraged; to help her/him to be able to constantly provide those opportunities for her/his students.

The Winthrop Pre-School Program: A Developmental-Behavioral Approach to Early Childhood Intervention in the Public Schools

by

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Winthrop, Massachusetts

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The Winthrop Pre-School Program: A Developmental-Behavioral Approach to Early Childhood Intervention in the Public Schools*

Adrienne Robb-Fund
Winthrop Public Schools
Winthrop, Massachusetts

Program Summary

Title

Winthrop Public Schools Pre-School Program
Winthrop, Massachusetts

Program Coordinator

Adrienne Robb-Fund
N.E. Wills School
Winthrop, Massachusetts 02152
(617) 846-5500 x 60

Major Objective

The major objective of the community based pre-school program is to intervene in the cognitive, language, social and motor development of pre-schoolers with special needs in order to prepare and to facilitate their entrance into the regular public school kindergarten.

Children Served

Children ages 3-6 who exhibit greater than one year delay in development or who are impaired in hearing, vision or speech, disturbed, retarded, or physically disabled.

The program services 15-20 pre-schoolers and their families per academic year.

Program Staff

The program is staffed by:

a. one full time special needs early childhood teacher
b. one half time speech and language clinician
c. two full time teaching assistants
d. physical therapy consultant
e. occupational therapy consultant
f. psychiatric consultant
g. Winthrop public schools psychologist
h. " " " social worker
i. " " " nurse

* Partially funded under Title VI b, Project #48-346-235 B.

The program is jointly supervised by:

a. Willis School principal
b. Winthrop Public Schools Special Education Director

The program is situated on the first floor of a regular elementary school. It provides:

a. 5 half day sessions per week per child
b. 1 half day session per week for parent/staff/in-service
c. open door policy for parent observation & participation
d. individual and group parent meetings with specified team members depending on need (teacher, social worker, psychiatrist, etc.)
e. opportunities for siblings and other students in the school to serve as classroom aides
f. opportunities for high school students to serve as aides
g. opportunities for integration with regular kindergartens
h. pre-school and kindergarten screening
i. services of the public school system (music, gym, nurse, cafeteria)

All evaluations are in accordance with Massachusetts law Chapter 766.

Background

In the Fall, 1975, Winthrop held a town wide screening for pre-schoolers ages 3-5. The screening was advertised in the local papers. One hundred pre-schoolers were screened in a one week period and another 100 were screened at a later time at two local nursery schools. The screening showed an incidence of 8% of those screened in need of some intervention. At the time the only services available for the pre-school child were private nursery schools for children with no special need and the Department of Mental Health Community Clinical Nursery Schools (DMH-CCNS). The DMH-CCNS program serviced children with primary retardation. In other words, we had identified a population in need of service, but had few resources or programs available to serve these children.

By Winter, 1976, a "mini program" was started. Eight of the identified children attended a program one afternoon per week for 14 weeks. The program was taught by a special needs teacher. The parents of the children attended a parents' group each week. This was led by the school social worker. The goal of the group was to teach parents to work with their children at home. Each week parents were given a list of activities that had been done in the classroom and some ideas as to how to follow through during the week. Of the eight children, three were found to not be in need of special services, three continued to receive support while attending regular kindergarten and it was recommended that two attend a full time intervention program. At the time there were no programs for these two children.

The need for some full time program for pre-schoolers with special needs was apparent. A proposal was written and State, Federal, and local funding was received in August, 1976.

Program Model

In preparation for the new program , the administrator gave the teachers the freedom to visit a variety of pre-school programs in and around Greater Boston. From these observations it became apparent that pre-schoolers were being taught in one of two models:

1. A highly structured teacher directed program in which the teacher chooses the material and the child performs the task.

2. An open classroom where children are free to experiment and explore with no remediation or prescription.

Both approaches have their merits. We decided to combine both and have based the philosophy on "developmental-behaviorism".

Developmental-behaviorism takes its name as it draws on both developmental psychologists (Gesell, Piaget) and behavioral psychologists (Mager, Hewitt). The curriculum content and classroom design illustrate the influences of Gessell, Piaget, and the open classroom enthusiasts in its use of child-directed learning centers. Behavioral teaching techniques such as task analysis, backward chaining, reinforcement and diagnostic prescriptions are employed. The children are free to move from center to center in the classroom. The teachers introduce the prescriptive lesson within the activity the child has chosen. These objectives are posted in the classroom. The teachers use the child chosen activity to attain the desired objective. For example, a child learning to articulate /s/ will do in all activities. If he's in the art corner he will articulate for Scissors and Some paste. If he's in the kitchen he'll be asked to make Sauce and Salad. The child chooses the activity. The teacher then uses the activity to attain the desired objective. There are times during the day when a teacher may choose the activity for the child as he needs to be 'taught' the next step. The teacher observes the child trying to use scissors. She then goes over to him to teach him how. She may need to backstep and have him use double handed sissors instead. The teacher communicates these goals to parents through individual monthly conferences and provides the parents with a list of at home activities.

Thus the child learns to generalize tasks throughout the day.

How does one create a learning environment that gives children the opportunity to manipulate their environment in an informal atmosphere and still adhere to the accountability movement and the behavioral objectives as seen in educational plans?

The floor plan of the learning environment is divided into areas providing for group and individual activities as follows: (See Figure I)

Puzzle Place: The puzzle place contains fine perceptual motor equipment such as:

large and small beads
non-interlocking & locking puzzles
sorting boxes
ring stackers
peg boards and pegs
form boards
grommets
nuts and bolts
screws and screwdrivers

Art Corner: Art activities provide for creative expression and fine motor skills. Supplies in a well stocked art corner include:

crayons, paste, paper, glue, chalk, double handed & regular scissors, clay, playdough
easels, watercolors, tempra paints, brushes, items from Recycle (childrens museum, Jamaica Plain, Mass.)
a carpenters workbench
water and sand tables-funnels, bottles, tubing
wallpaper books

Kitchen: The kitchen or playhouse area provides for language development, creative expression and role play. Items can vary. We included:

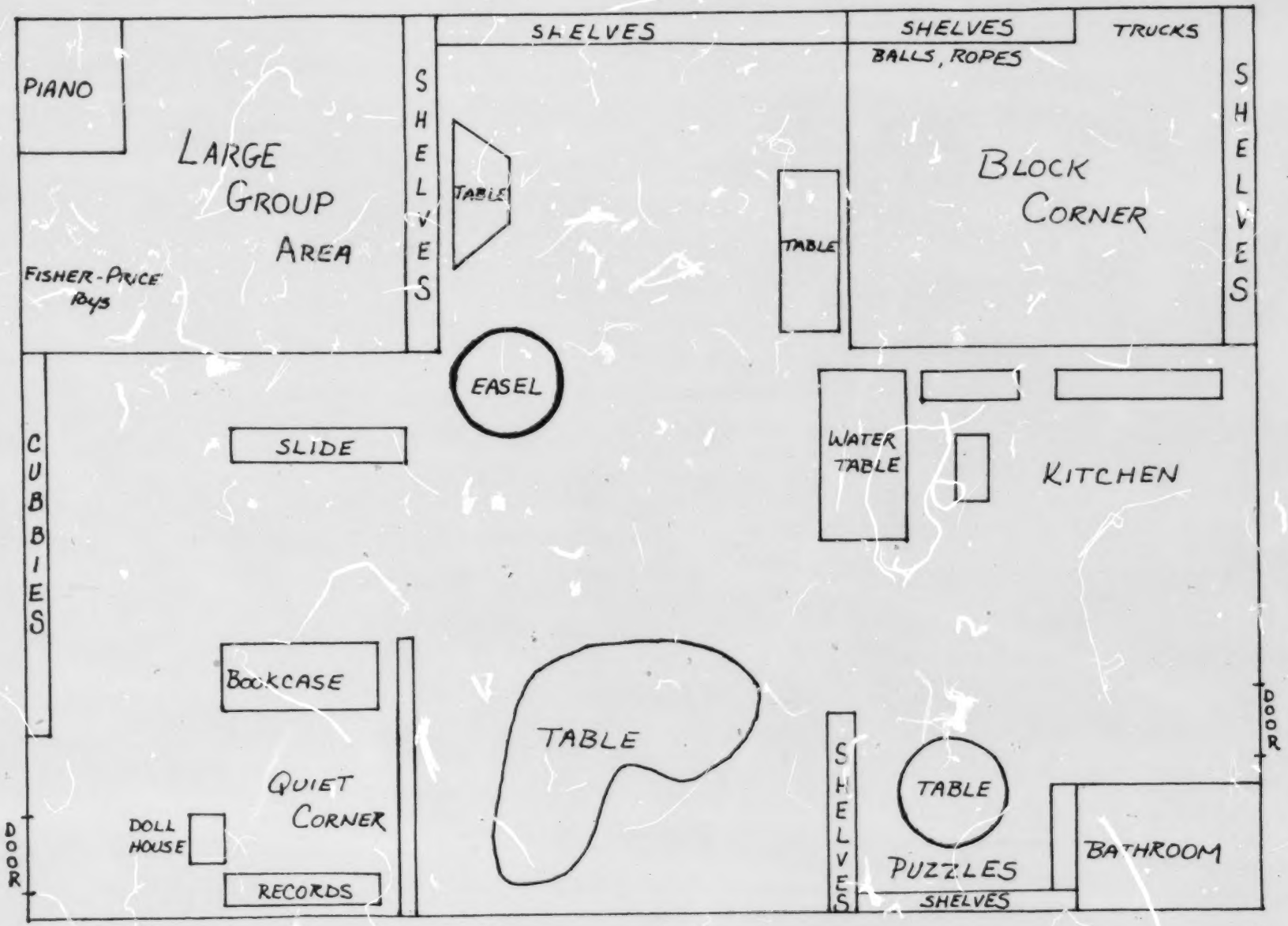
childsize play sink, stove, refrigerator, crib, highchair
an assortment of dishes both child and adult size
utensils, an assortment of dress up clothes, hats, jewelry, shoes, bags
an assortment of boxes from cereal, cookies
plastic fruits and vegetables, clay, mirror

Circle Rug: The rugged area provides a space for language activities and also serves as a group meeting place. In includes:

lotto and domino games
flannel board and story sets
tape recorder
language master
peabody early experience kits
puppets
story sequencing activities
Fisher Price playhouse, garage, and school house

Block Corner: Blocks provide children the opportunity to develop creative expression, learn size and shape discrimination, role play, and motor play.

FIGURE I


PIANO
LARGE GROUP AREA
FISHER-PRICE Toys
SHELVES
TABLE
SHELVES
SHELVES
BALLS, ROPES
TRUCKS
TABLE
BLOCK CORNER
SHELVES
EASEL
CUBBIES
SLIDE
WATER TABLE
KITCHEN
BOOKCASE
TABLE
QUIET CORNER
DOLL HOUSE
RECORDS
DOOR
SHELVES
TABLE
PUZZLES
SHELVES
BATHROOM
DOOR

unit blocks
large plastic blocks
trucks
street signs

Gross Motor: This area provides for building large muscle skills. Some of this equipment was found in one area, some of it in various places in the classroom.

balance beam, scooter boards
vestibular board, balls, ropes
romper stompers, slide, tricycle
vestibular tub, barrels-to climb through

Quiet Corner: We all need a place to sit by ourselves, relax, read a book-so do pre-schoolers. Our quiet corner was carpeted with carpet samples and included:

pillows, stuffed animals
rocking chair, record player and headphone set, records
puppets, books
guinea pig

One of our problems in setting up this type of program was the need to develop weekly and daily objectives for each child that took into account his making choices about his learning. We were being pressured by our administrator for a "time-block" schedule including objectives and we wanted to give the child choices.

We resolved this conflict by setting up a schedule in which the classroon day is divided into twenty minute time blocks. Objectives are written for each child during each time interval. (See Figure II) Some objectives cover more than one interval and others should be taught the entire day. These extended objectives, therefore, are carried out at appropriate teaching times throughout the day.

Flow charts are posted in each area of the classroom. These describe all the general objectives that can be reached in that learning area. The flow chart for the kitchen area can be seen in Figure III. The kitchen area can be used to teach social studies, social development, art, language, science, math and motor skills. Children practice naming, pouring, classifying etc...

This same format is used to define the objectives, for each child at each center. Figure IV shows a copy of one child's flowchart for one quarter. The general goals for the child in each area are described.

Flow charts are also used to determine specific curriculum content. For example, a general objective for all children is to recognize and identify the color "red". A flowchart was developed to outline series of activities used to teach "red" both in the centers and in the large and small group activities. (Figure V)

Figure II

GENERAL OBJECTIVES

	Child 1	Child 2	Child 3
9:00	will take coat off independently will respond to 3 direct questions	will take coat off when teacher removes it to wrist. will sit for 5 minutes.	will take coat and hat off and hang on hook
9:20	will play in 2 areas will engage in cooperative play for 10 minutes.	will play with a toy independently for 5 minutes.	will play cooperatively for 20 minutes
9:40	will cut 3" line will color independently will copy square	will make large lines at easel with hand over hand assistance	will color simple design will cut a circle
10:00	will ask for snack will clean up	will say "Eat" for snack	will pour juice will clean up
10:20	will pump independently on swing will throw & catch with adult	will walk to playground with only 2 falls	will play cooperatively with other children for 20 minutes
10:40	will respond to 3 direct questions	will imitate 1 word sentence	will sequence 4 part story
11:00	will imitate body movements will name body parts	will point to head, feet, tummy, arms	

Figure III

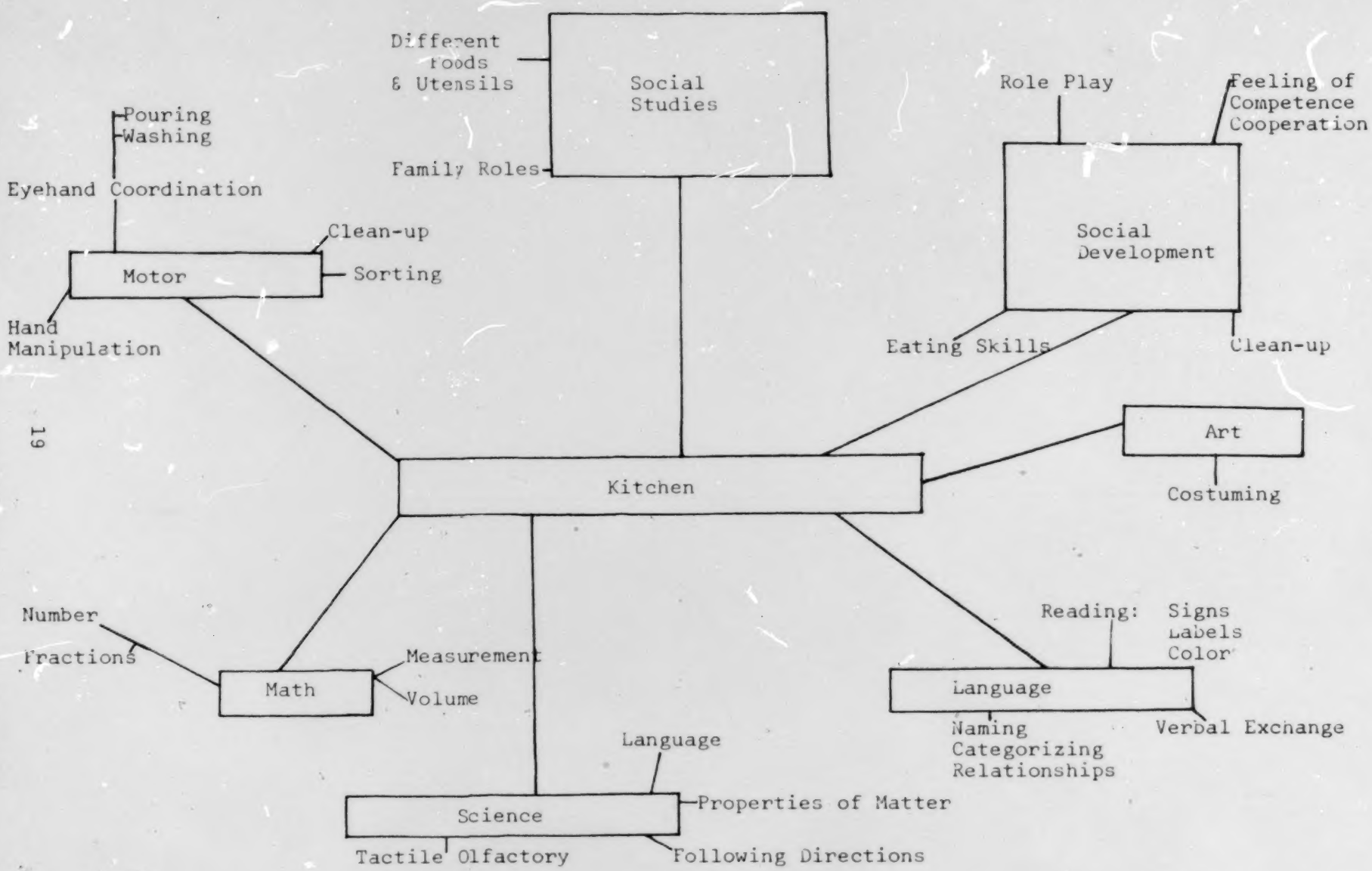

Different Foods & Utensils
Social Studies
Family Roles
Role Play
Feeling of Competence Cooperation
Social Development
Eating Skills
Clean-up
Pouring
Washing
Eyehand Coordination
Clean-up
Motor
Sorting
Hand Manipulation
Art
Costuming
Kitchen
Number
Fractions
Math
Measurement
Volume
Reading: Signs Labels Color
Language
Naming Categorizing Relationships
Verbal Exchange
Language
Science
Properties of Matter
Tactile Olfactory
Following Directions

Figure IV

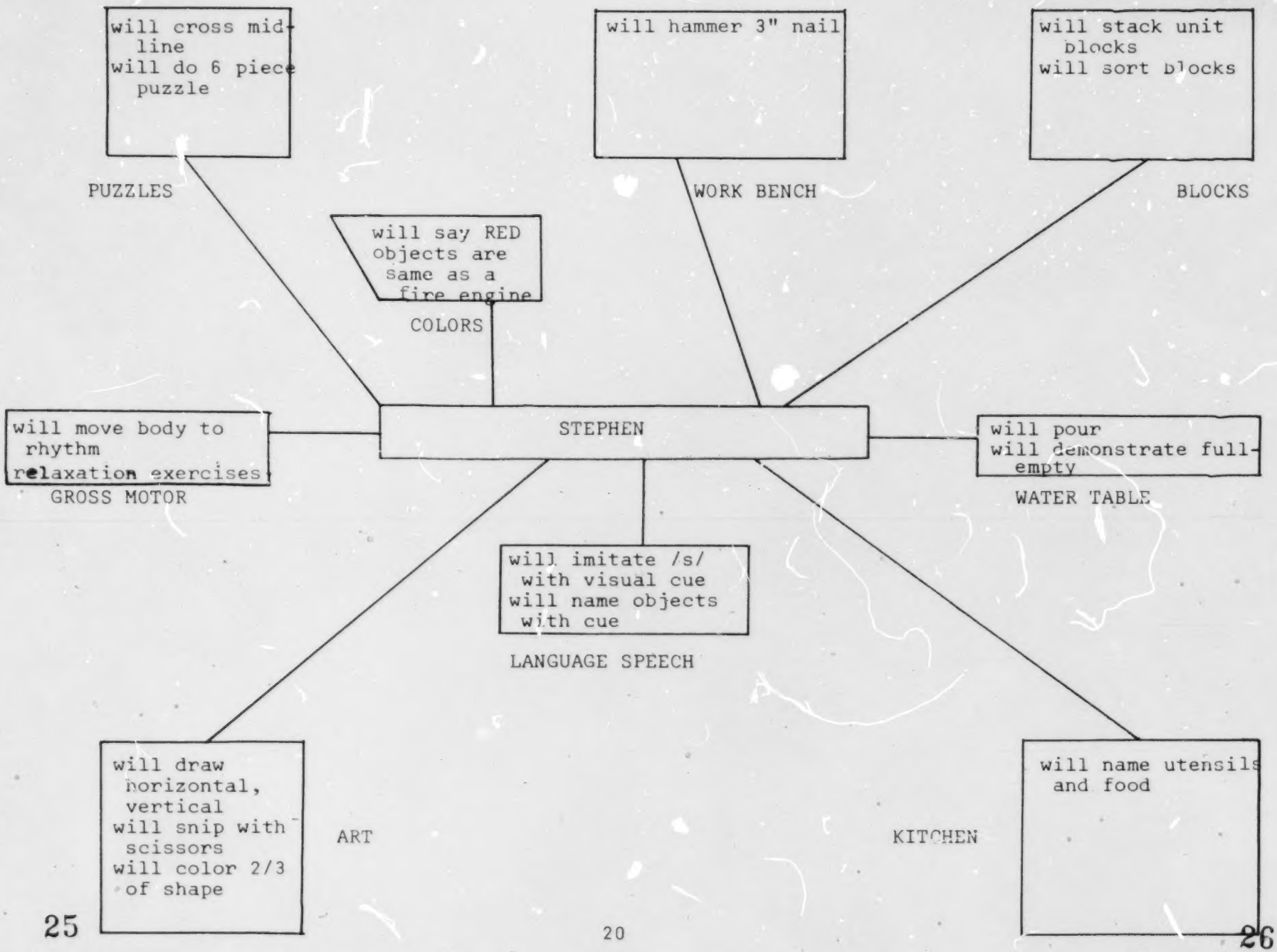
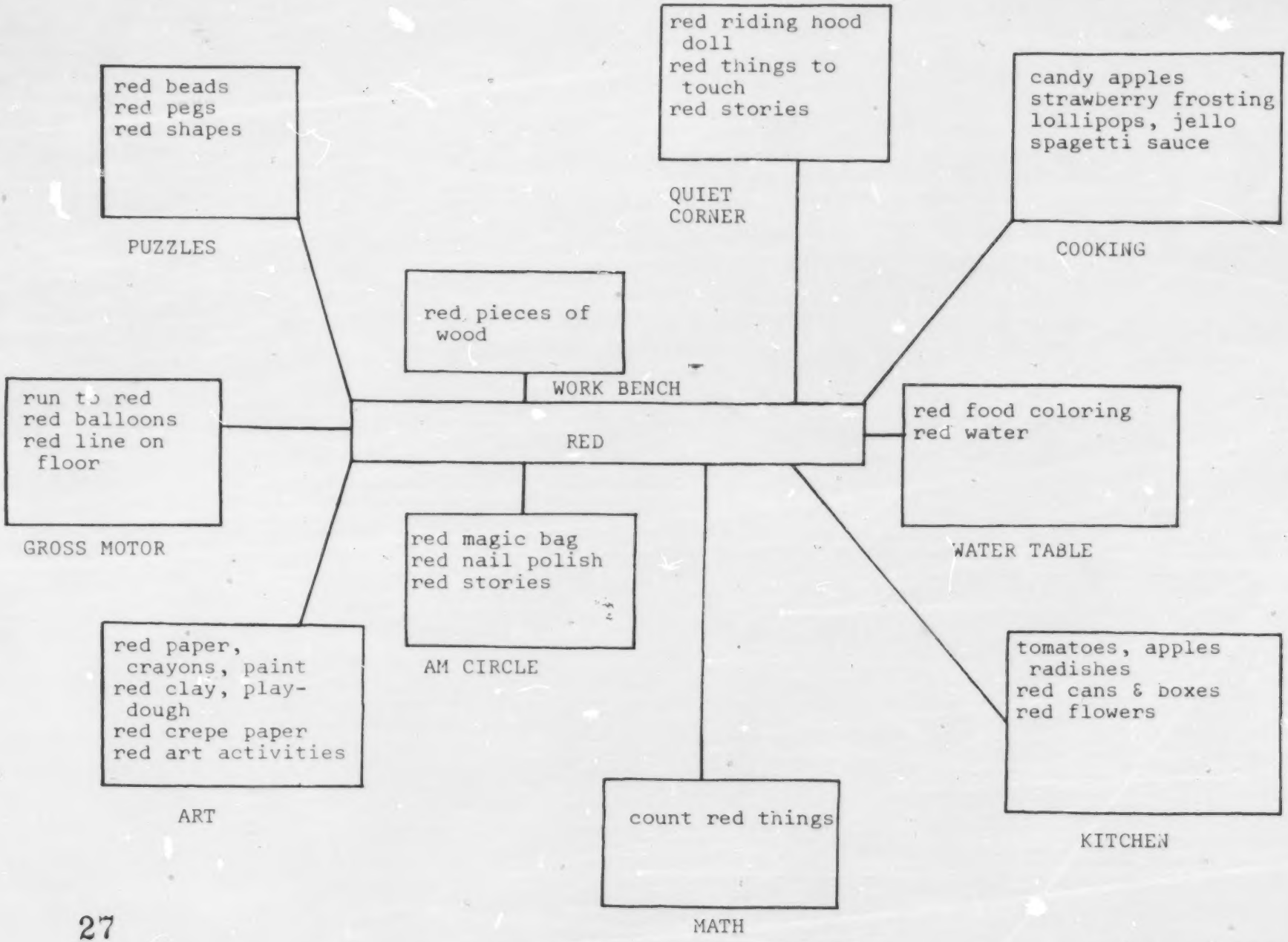

will cross mid-line
will do 6 piece puzzle
PUZZLES
will hammer 3" nail
WORK BENCH
will stack unit blocks
will sort blocks
BLOCKS
will say RED objects are same as a fire engine
COLORS
STEPHEN
will move body to rhythm
relaxation exercises
GROSS MOTOR
will pour
will demonstrate full-empty
WATER TABLE
will imitate /s/ with visual cue
will name objects with cue
LANGUAGE SPEECH
will draw horizontal, vertical
will snip with scissors
will color 2/3 of shape
ART
KITCHEN
will name utensils and food

Figure V


red beads
red pegs
red shapes
PUZZLES
red riding hood doll
red things to touch
red stories
QUIET CORNER
candy apples
strawberry frosting
lollipops, jello
spagetti sauce
COOKING
red pieces of wood
WORK BENCH
run to red
red balloons
red line on floor
GROSS MOTOR
RED
red food coloring
red water
WATER TABLE
red magic bag
red nail polish
red stories
AM CIRCLE
red paper, crayons, paint
red clay, play-dough
red crepe paper
red art activities
ART
count red things
MATH
tomatoes, apples radishes
red cans & boxes
red flowers
KITCHEN

The objectives from the various consultants (physical and occupational therapy) were also recorded in this way. This aides in generalization and enhances learning.

Daily Schedule

Below is the regular daily schedule, activities and some methods used. It is important to note that within this structure is a hidden structure which meets each individual's needs.

8:30 Teacher planning
9:00 Arrival of children: self help skills
9:10 Circle time: cognitive, sensory, and gross motor activities; finger plays, rhythm.
9:30 Choice play time: individual prescriptive teaching time, social interaction, cooperative play skills.
10:30 Snack: meal time skills, cooking, tasting
10:45 Group language time
11:10 Gross motor, speech, art skills
11:30 Prepare to go home: self help skills

Parents

Parents are an integral part of the Core Evaluation Team and pre-school program. When planning for parents, goals are individualized to the parents needs. Some parents work in the classroom, some observe, some have home teaching programs, some are visited at home.

Parents meet with the teachers on a regular basis. Monthly individual conferences are held. Monthly group meetings are held as well. Specific programs have centered on self help skills, behavior management techniques language and cognitive development and gross motor development.

The program will be establishing a library of materials for parents.

Consultants

A physical therapist, occupational therapist and psychologist consult to the program one day a week. These specialists help evaluate the children. Programs are written by the various specialists and carried out throughout the day by all the teachers and aides. The consultants help the teachers develop the skills they need through teacher training and modeling during their consultation time. They may see some children on a one-to-one basis.

Screening

Winthrop holds a town wide screening for three and four year olds each fall. Three children are screened together during a 40 minute time period. Screening is held in the pre-school classroom. Screening is staffed by a special needs teacher, speech and language clinician and one aide. Children enter with their parents and are invited to play. Puppets are used to help the child feel at ease in the classroom setting. The materials available are chosen and set up so that the children's choices will reflect the specific development information we want to

know: color and shape matching, recognition, naming, design copying, fine motor skills, gross motor skills, social and play skills, language skills, and draw a person. Some of the materials specifically placed on tables around the room include: 1-inch color cubes, attribute block, sorting boxes, puzzles, crayons, markers, scissors, pegs, and peg boards, beads, balance beam, clay, interesting pictures of children engaging in activities, balls, etc. The child is free to choose and move to whatever activity he chooses. The teacher (tester/evaluator) knows in her head exactly what information he/she needs to screen the child. She begins at the place where the child is at play and plays with the child in order to develop a relationship with him/her. The teacher then begins to do some of the screening through the materials the child has selected. As the child feels more and more comfortable with the teacher, the teacher increases her input into the direction of the activity. The child still is given a choice and may be asked which he wants to do first, etc. In this way the pre-schoolers first experience with school is a warm, positive one.

For example, the child who comes in the room and is clinging to his/her parent is told with puppets that it's okay to feel shy. Often the teacher will use a puppet (we like Seseme Street puppets as children generally are familiar with the characters) who talk about feeling afraid and is accepting of the child's feeling. The child sees the other children playing with some blocks and meanders over. Spying the colored clay he begins to mold. The teacher, sensing that the child feels comfortable, begins to play with clay too, talking with the child. She may ask the child to find her clay that's the same color, or put the clay on a block of matching color or on the square, etc. As the teacher/child relationship develops, she asks the child to do various other tasks. The final task is the drawing of a person. The child is usually asked to draw a picture of himself or herself so the teacher can remember who she/he is.

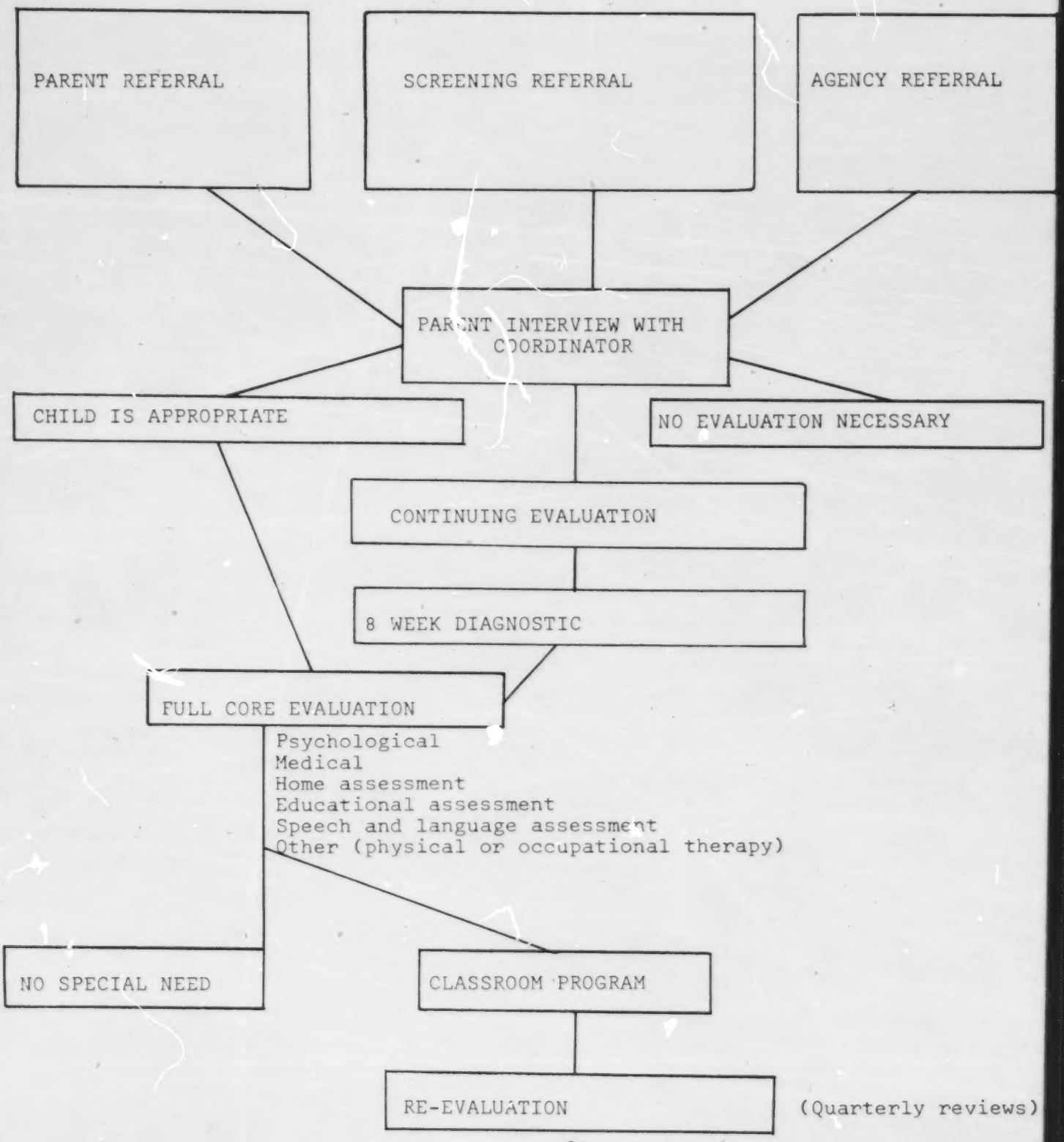
The important key for the teacher is to be flexible and to let the child "guide". If we have some concerns about the child we contact the parents and invite them and their child to come again. The same approach as described is used. If we still have concerns or questions, the child enters the pre-school program for an extended diagnostic period of 8 weeks.

Intake (Figure VI)

Children are referred to the program as a result of referral from their parents, nursery school or pediatrician or as a result of the pre-school screening. The coordinator interviews the parent to discuss the child and then works with the child. If the coordinator and parent feel the child is an appropriate candidate for the program, a Core Evaluation is held immediately. If there is some question as to what program is appropriate for the child, or if there are other diagnostic questions,then evaluation is continued and the child enters the program for an eight week diagnostic evaluation in the classroom.

Figure VI

Intake Procedure



The Full Core Evaluation consists of the following components: psychological, medical, home assessment, and if necessary, physical and occupational therapy assessments. The parents are members of the Core Evaluation Team. The team decides the goals and placement for the child. They write the educational plan. The child is then placed in the appropriate program.

The educational objectives for each child are developed using findings from the Core Evaluation assessments as well as the results of a variety of formal and informal techniques. Some of the formal techniques that may be employed include:

1. Assessment of Children's Language Comprehension (ACLC) Consulting Psychologists Press. 577 College Ave., Palo Alto, Calif.
2. Detroit Tests of Learning Aptitude
   Bobbs Merrill, Indianapolis, Indiana
3. Developmental Task Analysis (Valett)
   Fearon Publishers, Belmont, Calif.
4. Developmental Test of Visual - Motor Integration (Beery)
   Follett, Chicago, Illinois
5. Goodenough-Harris Draw a Person
   Harcourt Brace Javonovich, NY , NY
6. Peabody Picture Vocabulary Test
   AGS, Circle Pines, Minnesota
7. Stanford-Binet Intelligence Test
   Houghton Mifflin, 53 West 43rd St., NY, NY
8. Vineland Social Maturity Scale
   AGS, Circle Pines, Minnesota
9. Wechsler Pre-school and Primary Scale of Intelligence
   Psychological Corporation, NY, NY
10. Performance Objectives for Pre-school children
    Adapt Press

As our major goal we want to successfully mainstream the children into kindergarten, we do not use educational or psychological labeling.

Children are evaluated in terms of learning strengths and styles and developmental norms. These are recorded on performance skills checklist (Performance Objectives for Pre-school Children) and in an educational assessment. These are then transferred into 3, 6, 9 and 12 month goals on the educational plans as per Ch. 766. (See Appendix)

Specific objectives are chosen for each child to attain within the 3 month cycles. Teaching begins at the child's current developmental level and sequential tasks are designed. Materials are then placed in each learning center to create opportunities for the child to learn the new skill. The teachers note the child's progress through the daily observations.

The child's progress is discussed during the teacher's daily preparation time and during weekly team meetings. Any changes are then put into effect.

Follow-up

During the 1976-77 school year the program serviced 12 children. Of these 12, 2 are currently in regular first grade classrooms with support services, 6 are in kindergarten programs, 1 is in a transitional K-1 program, and 1 is in a self-contained special needs program. One child moved to another state, the other to a foster home in another town.

The Speech/Language Clinician as Clinician, Co-Teacher and Teacher Trainer

by

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Maria Walsh

The Speech/Language Clinician as Clinician, Co-Teacher and Teacher Trainer

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The onset of Chapter 766 requiring education for all special needs children between the ages of 3 and 21 has not only called for the revamping of parts of regular education, but also for the redefining of the specialist's role.

This morning I would like to tell you how the Speech/Language Clinician's role as a specialist was redefined through the evolution of the Winthrop Pre-School Project.*

Background

What were the reasons for this needed change in the specialist's role? First, the number of children in need of speech and language services now in the mainstream of public education has increased tremendously. Secondly, we are now also servicing children with more severe speech and language problems. This, coupled with mandatory special education for 3 year olds in need, raises the question of whether the traditional "one-to-one therapy outside the classroom structure" is the most effective method of teaching.

Let me speak for a few moments about the traditional role. The traditional role of speech and language therapy "outside the classroom" has made the generalization of what's learned in therapy difficult and more time consuming for several reasons.

1. The clinician can only spend a limited amount of time with the child. At most an hour a week.
2. The new speech and language skills can be lost outside therapy because they are not reinforced enough throughout the child's normal day.
3. Therapy outside the classroom does not give the regular or special education classroom teacher the opportunity to learn how he or she might reinforce better speech and language skills.
4. The traditional role does not allow the clinician the opportunity to observe children in their natural environment nor give her the chance to assess true ongoing spontaneous language.

Since three year old children are not "traditional" to public education, several questions arose concerning the appropriateness of using this traditional model with them in the Winthrop Pre-School Program. It was apparent that the children we would be servicing would most probably have vast speech and language needs. The need for the special education teacher and the speech and language clinician to spend alot

* Partially funded under Title VI b, Project #48-346-235 B.

of time together was also apparent. So it was decided that they would "team teach". Exactly what that phrase "team teach" meant was not defined at the beginning but left to evolve as the needs of the children were made evident. And so it did.

Before going on to describe what evolved over the past year, let me spend a few moments talking about why the nature of the three year old child generated this change.

What was going to be the major goal for most of our children? It was to develop language; not necessarily remediate at first. Most of our children need help in building good solid beginning cognitive language (ie: grammer, syntax) and speech skills. The next question that came to mind during the designing stages was how does the average child learn? He learns from his environment, through play and by absorbing everything that's going on around him. He starts from his wants, needs and interests and within five years the small child has accomplished an enormous task: HE HAS LEARNED TO BE A COMPETENT SPEAKER OF THE ENGLISH LANGUAGE!

The average three year old uses his environment to teach himself language. He touches, smells, and explores everything around him. Then when he has reached a level of sophistication he starts asking the never ending three year old question, WHY?

How do you help that special child who is having trouble mastering this task on his own? You watch, observe and constantly re-evaluate. Let the child guide you; that is our philosophy.

And out of that philosophy has grown a teaching style that helps children develop rich speech and language skills.

Program Model

Language learning is a dynamic process and so the language learning environment must be the same. As described in the flow charts, all areas in the room are designed to develop all skill areas of each child. (See Robb-Fund paper, Figure III) For example, if it is observed that a child's knowledge of food categories is limited, the teachers will make sure that the pretend foods that we want the child to learn are placed in the kitchen area so that he will come into contact with them during free play. The identification of these food categories will then be reinforced during the group language circle, during a cooking activity, at lunch, and when walking to the local store. The same outline can be used to teach other categories such as animals, transportation, clothing or whichever classification the child needs to learn. The idea is to set up the environment with high interest toys and equipment - ie: puppets, movable toys, stuffed animals, etc. - all items which attract the children. Then use these as teaching tools. We often use puppets to increase the shy child's verbal output. To a child, a puppet is less threatening than an adult. We have observed children talking more readily to puppets at first. This gives us the opportunity to assess spontaneous language in a comfortable and child generated method.

The environment is not only designed to generate and develop rich language skills, but it also has individuals trained to look at how they can use each experience and encounter with the child as a possible time to develop speech and language.

The role of the speech/language clinician

Co-Teaching

As the children developed so did the teachers. The concept of "team teaching" quickly evolved into co-teaching. What this means is that we often teach simultaneously. The language time is not a planning period for the teacher, nor is gross motor time a free period for me.

Most activities, when scheduling allows, are run by one teacher. The other teacher observes how each child is grasping the skill as that child interacts with the other students. This gives each child the benefit of all our expertise during each activity. It is not unusual to observe one of the teachers subtly giving the other a sign to hold the lesson at that immediate moment. What has usually occurred is that one of the teachers has observed an excellent chance to develop a skill during the natural flow of an activity. We other teachers will gracefully work that teacher into the lesson even though we are not sure exactly what the other teacher has in mind. Some specific examples are as follows.

1. While watching the teacher or aides use puzzles as a motor activity, it became clear that they often bypassed a wealth of language time while doing motor and visual perception activities. By explaning to the teacher how she could use these times to develop language, she not only became a teacher of visual perception skills and motor skills but also an excellent language teacher.

2. Vice versa, during the language circle while teaching the color "red" one day, it became clear to the teacher that I could better work on the figure ground skills of the children by having them choose from objects on the floor rather than pointing or touching all of the red objects in the room.

What has evolved through this co-teaching effort is a realization that often we as specialists can learn a tremendous amount from each other's areas of expertise. The result is that the child gets more effective and total "child oriented" teaching.

Clinical/Teacher Trainer

There are also children who need a "one-to-one" situation for developing speech and language, motor, and/or visual perceptual skills. Blocks of time are set aside to work intensively on these skills but always within classroom settings. This allows the teachers to act as models for

each other and often the children take over the role as model for each other. An example of this was observed in the use of Motor Sequential Tactile Therapy (MST). This is a technique used in articulation therapy which couples a finger cue with a touch cue to help children learn new phonemes.

Last year when several of the children had moved to the point in individual therapy where they were expected to say the initial phonemes they were working on in words; the finger cues were taught to the other teachers and parents. They were instructed to reinforce the sound in the appropriate position whenever they heard an opportunity occur during the day's activities. Soon most of the children had picked up the cues and thought of the signs as a game. They quickly moved into monitoring each other. One little boy whose speech was extremely rapid was helped to slow down through gross motor activities and a simple visual cue (a hand in a slow swaying motion) which all the teachers could easily reinforce in most other activities.

Role overlap

As you may have realized, my role as clinician and teacher trainer often overlap.

As clinician, I view my role as mostly a diagnostician and developer of speech and language programs. I may initally need to start a child on a "one-to-one" but it is the team effort in the classroon and at home that reinforces the skill so that it becomes mastered by the child.

As teacher trainer, I have tried to give the teachers the knowledge that I have about speech and language so that they may better understand what to expect from a child and to help them better understand the child's behavior. (For example: explaining instances in which I want teachers to reinforce one seven word sentence a child uses rather than another one because of the difference in grammatical structure between the two). I hope, if anything, I've tried to get the teachers to begin to really think about the structure of language and all the complexity of teaching it. Also I hope I've imparted that it is not a mysterious, overwhelming task that only someone trained in speech and language can do, but rather one that requires a trained clinician to diagnose and plan the program. The teacher is the child's primary language model all day and the classroom is the best language environment.

Conclusion

My experience in the Winthrop Pre-School has added tremendously to my growth as a clinician. My other half time responsibility in the Winthrop School System is at the secondary level. Sometime last January, it became clear to me that this model or at least part of it would be

extremely effective at all levels of education. I then took steps to redefine my role at the secondary level. I now spend one third of my time at this level within the classroom structure and consulting with teachers. It has given me clearer insights into the needs of my students, which has generated more realistic therapy sessions. I am also training teachers to teach more effectively to the speech and language disabled child in his or her junior high History or English classroom.

I feel strongly that my thougnts, feelings and philosophy came from watching the average three year old absorb and internalize the world around him. He taught me a great deal about how people learn and this is what I hope to take to each teaching encounter.

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The list below represents some of the literature the teachers found useful in developing the program model.

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Appendix

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF EDUCATION
DIVISION OF SPECIAL EDUCATION
182 TREMONT STREET, BOSTON 02111

Identification #_____
School_____
Grade_____
(319) Type Core_____
Date_____

(321.0) EDUCATIONAL PLAN:

GENERAL AND SPECIFIC OBJECTIVES/DELIVERY OF SERVICES

1. Name_____ Date of Birth_____

Address_____ City_____

Phone_____

2. Participants:

Name	Position	Name	Position

3. This Educational Plan covers the period_____ to _____.

4. General Objectives:

Based on the various demonstrated performances as indicated by the assessments, what are the general long term (one year) objectives for the student?
In what program will these objectives be met?*

Pri No.	OBJECTIVE	PROGRAM # *

*regular education 1.
reading 2.
adapted regular education 3.
special needs 4.
others 5

/___/ Attach extra sheet, if necessary

5. Learning Style/Physical Constraints/Performance Level (321.1 (a) (b) (c))

Provide information relevant to the instruction and attainment of objectives.

/____/ Attach extra sheet, if necessary

6. EDUCATIONAL OBJECTIVES (321.1 (d)/321.2) 6.1 (.2(a)) 6.2 (.2(c)) 8.1(.2(3)(.4(d)) 8.2 (.4(g)) 8.3 (.4(a/b))

CORE EVALUATION TEAM			1	2	3	4			
Pri. No.	Spec. Obj. #	SPECIFIC OBJECTIVES	Quarters (12 Mo./Yr.) i.e., 3 Mo. Intervals				Class	Small Group	Individual

ADMINISTRATOR OF SPECIAL ED./DESIGNEE				
Type of Program		Start Date Mo/Day/Yr.	SERVICE	
Regular	Special		Provider	Location

CHAIRPERSON'S COPY

6.

		CORE EVALUATION TEAM	6.1				6.2				ADMINISTRATOR OF SPECIAL ED./DESIGNEE				
											8.1		8.2	8.3	
Pri. No.	Spec. Obj. #	SPECIFIC OBJECTIVES	Quarters (12 Mo./Yr.) i.e., 3 Mo. Intervals				Class	Small Group	Indiv-idual		Type of Program		Start Date Mo/Day/Yr	Service	
											Regular	Special		Provider	Location

Total:_____Hours per week_____days per year. (321.2(f) (g)/321.5 (a) (b))

7. Participants (Signatures)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

9. Additional information: _____

_____

_____

_____

_____

_____

_____

_____

10. Program Prototype:_____

_____

CHAIRPERSON'S COPY

45

11. Criteria (demonstrated skills) for student's movement to next less restrictive program prototype. (321.5(d))

_____

_____

_____

12. Describe this student's transportation plan. (321.2(h)/321.5(c))

_____

_____

_____

13. Designated liaison person. Name: _____

Position: _____

14. If placement outside the LEA is recommended complete the following: (322.3)

I certify that the (facility) _____ is able to provide the services required by this plan.

Signature _____ Date _____
(Director of Accepting Facility)

15. I certify that the above objectives are those recommended by the core evaluation team, and that the above indicated services will be provided.

Signature _____ Date _____
(Special Education Admin./Designee)

16. I certify that the above objectives are those recommended by the core evaluation team, and that the above indicated services will be provided.

Signature _____ Date _____
(Building Principal)

17. Response of Parents/Guardian/Student:

a. /___/ I accept the educational plan outlined above.

b. /___/ I DO NOT accept the educational plan outlined above.

c. Comments; _____

_____

I understand that I may seek a second opinion or independent evaluation as provided in the Chapter 766 regulations.

Signature _____ Date _____
(Parent/Guardian/Student)

CHAIRPERSON'S COPY

CET #_____

WINTHROP PUBLIC SCHOOLS
DEPARTMENT OF SPECIAL NEEDS
WINTHROP, MASSACHUSETTS

REVIEW OF STUDENT PROGRESS (as per 766 Reg. 332.0)

NAME:_____ PRESENT PROGRAM:_____

SCHOOL:_____ LIAISON STAFF:_____

GRADE:_____ DATE:_____

_____ has been in a special needs program as described in this student's educational plan for _____ months. During this time _____objectives established in the educational plan have been met, as specified (on the educational plan or on the attached sheet.)
At the present time _____ objectives are being worked with.

The following plan for further services from the Special Needs Department is recommended.

/___/ 1. Continuation of the plan as written (Reg. 332.1 (c))

/___/ 2. Continuation of the plan as written with modifications specified on the attached page (Reg. 332.1 (c))

/___/ 3. Change of Program (Reg. 332.1)

/___/ a. Program no longer needed. All objectives have been met.

/___/ b. Less restrictive program. Specify type_____

_____

/___/ c. Different program. Re-evaluation needed.

PROGRAM COORDINATOR_____

CET CHAIRPERSON_____

BUILDING PRINCIPAL_____

PARENT/GUARDIAN/STUDENT_____

A. /___/ I accept the program review outlined above.

B. /___/ I do not accept the program review outlined above.

I understand that I may seek a second opinion as provided in the Chapter 766 regulations.

CHAIRPERSON'S COPY

CET #_____

WINTHROP PUBLIC SCHOOLS
DEPARTMENT OF SPECIAL NEEDS
WINTHROP, MASSACHUSETTS

DIAGNOSTIC PROGRAM (Reg. 502.9)

NAME_____ PRESENT PROGRAM_____

SCHOOL_____ LIAISON STAFF_____

GRADE_____ DATE_____

_____ was evaluated on _____

by a partial/full core evaluation. The CET is unable to set objectives for this student to achieve at this time and is consequently unable to write an educational plan for the child. Therefore, the following diagnostic program is recommended (Reg. 502.9 (b))

QUESTIONS	PROCEDURES	PROVIDER/ SCHEDULE

/____/ Attach extra sheet if necessary

As soon as the CET has a better understanding of this student's needs, but not later than _____ which is five days before the end of the eight-week diagnostic period, a meeting will be held to write the educational plan.

CET Chairperson_____

Program Coordinator_____

Building Principal_____

Parent/Guardian/Student_____

CHAIRPERSON'S COPY